Report on the Harris County Mental Health Jail Diversion Pilot Program for Fiscal Year 2016

As Required By
Senate Bill 1185, 83rd Legislature, Regular Session, 2013

Health and Human Services Commission
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Contents

1. Executive Summary

Senate Bill (S.B.) 1185, 83rd Legislature, Regular Session, 2013, required the Department of State Health Services (DSHS) to evaluate and submit a report on the effectiveness of a mental health jail diversion pilot program designed to reduce jail recidivism and frequency of arrest and incarceration among persons with mental illness in Harris County.

Report requirements include a description of the criminal justice mental health service model developed and tested under the pilot program and the Health and Human Services Commissioner's recommendation whether to expand the model statewide. The report is to be released to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and presiding officers of the standing committees of the Senate and House of Representatives having primary jurisdiction over health and human services and criminal justice issues.

Harris County Mental Health Jail Diversion Pilot (MHJDP) program was developed as a collaborative model in which health and human services and criminal justice agencies work together. Additionally, the program incorporates core elements of an empirically supported, time-limited case management model called Critical Time Intervention (CTI). CTI has successfully been used to assist people with behavioral health disorders who are transitioning from institutional settings, and who are homeless or at risk of homelessness, by improving continuity of care and access to services during the critical transitional period.

Persons with serious mental illness, high criminogenic risk, and previous encounters with the mental health system were eligible to participate in MHJDP. In most cases, individuals were referred to the program if they were identified through the Frequent Detainee List (FDL).

For fiscal years 2015 and 2016, 4,155 individuals were referred to the program:

- 1,385 individuals were engaged by the program, which means they were screened and assessed but did not meet the eligibility criteria.
- 554 were enrolled in the program, which means they were determined eligible for the program after screening and assessment.

Based on data and analysis provided by Harris County through a contract with the University of Texas Health Science Center Houston (UTHSCH), it appears the program was effective. In the first year following enrollment:

- Jail bookings and charges decreased by 0.8 percent per person.
- Felonies and misdemeanors decreased by 0.1 and 0.6 percent per person, respectively.
- Jail days decreased by 18.9 days per person, equaling a potential savings of $571,564 to Harris County per its estimates.

Use of evidence-based intervention models and best practices, such as integrated primary and behavioral health care, Motivational Interviewing (MI), CTI, Permanent Supportive Housing (PSH), Trauma-Informed Care (TIC), and Cognitive Behavioral Therapy (CBT) for criminogenic risk contributed to the program's effectiveness.

An essential component of CTI, strong collaboration, input, and buy-in from stakeholders, including local law enforcement, mental health agencies, and the courts also contributed to the program's effectiveness. Harris County used the Sequential Intercept Model (SIM) framework for developing community partners. SIM identifies gaps and resources within the criminal justice system and the community and helps communities understand how they can intervene at different points in time when individuals are identified as needing services.

Based on Harris County's findings, HHSC recommendations regarding expansion of the model statewide that could be implemented via existing local authority performance contracts include the following:

- Ensure the Consolidated Local Area Service Plans required by the performance contracts with the Local Mental Health and Behavioral Health Authorities include local jail diversion strategies which have a strong focus on interagency collaboration.
- Employ the best practices of SIM and CTI, as utilized in the pilot implemented in Harris County, in jail diversion projects, should funding be available for the expansion of jail diversion projects.

2. Introduction

S.B. 1185 mandated DSHS to implement a pilot program, in cooperation with the Harris County judge, to reduce recidivism and the frequency of arrest and incarceration rates among persons with mental illness in Harris County. The bill further stipulates the criminal justice mental health service model used to develop the program must apply CTI principles and be evaluated.

Funding for implementing the pilot program in cooperation with the Harris County judge was allocated by the 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015, (Article II, DSHS, Rider 66). For each fiscal year, $5 million was allocated. The Harris County Commissioners Court was required to contribute funding to the pilot program in an amount equivalent to the funds provided by the state.

Per legislation, the MHJDP program was developed and administered by the DSHS Mental Health and Substance Abuse (MHSA) division. However, S.B. 200, 84th Legislature, Regular Session, 2015, transferred DSHS to the Health and Human Services Commission (HHSC) on September 1, 2016. HHSC is now responsible for implementing S.B. 1185 and Rider 66, and the former DSHS MHSA division is now the HHSC Behavioral Health Services Section.

The legislation states in designing the criminal justice mental health service model the county judge shall seek input from and coordinate the provision of services with the following local entities:

- Harris County Sheriff's Office
- Harris County District Attorney's Mental Health Division
- Harris County Public Defender's Office
- Mental health courts
- Law enforcement officers trained in Crisis Intervention Training law enforcement and crisis intervention response teams
- Providers of the following services:

- Competency restoration services
- Homeless services
- Forensic case management services
- Assertive community treatment
- Crisis stabilization services
- Intensive and general supportive housing services
- Integrated mental health and substance use inpatient, outpatient, and rehabilitation services

In June 2013, Harris County began the development process for the pilot program. The first year involved a comprehensive planning process with individual and small focus group meetings with behavioral health, criminal justice, and law enforcement stakeholders. Stakeholders provided input to establish eligibility criteria, program model, service delivery, and evaluation components.

In June 2014, the program hired key staff and enlisted providers. Client services began in August 2014.

3. Background

There is a substantial need for robust jail diversion efforts in Harris County.[1] Out of 3.1 million adults in Harris County, 516,362 have a mental illness.[2] There is a daily average of 9,000 inmates at the Harris County Jail, and 2,400 have a mental illness.

Incarcerated individuals with a mental illness have a higher rate of recidivism compared to the general population. On average, those with a mental illness are arrested six times more often than those without a mental illness.[3] Once incarcerated, offenders with a mental illness remain in jail for longer periods, serving 40 percent more days of their sentences compared to other inmates.

The costs associated with frequent incarceration and longer length of stays for individuals with mental illness is high. The average cost per day in a mental health unit in the Harris County Jail is $232 per day compared to $57 per day for general population.[4] Treatment in jail settings is environmentally restrictive and available mental health services are limited. Typical costs associated with mental health treatment in jails are due to psychotropic medications and oversight by medical staff.
Providing community-based services to individuals with mental illness and high criminogenic risk factors ranges from about $22 to $42 per day. Diverting individuals from jails and linking

[1] *Mental Illness in Harris County: Prevalence, Issues of Concern, Recommendations* (Rep.). (2015). Mental Health Needs Council, Inc. Retrieved September 13, 2016, from http://mhneedscouncil.com/reports/2015-mental-health-needs-council-report/.
[2] Harris County - Jail Population June 2016 Report (Rep.). (2016). Harris County Budget Management Department, Office of Criminal Justice Coordination
[3] Nguyen, T.D., Hickey, J.S. & Farenthold, E. "Criminal Offending and Mental Disability in Harris County: Mental Health Treatment and Subsequent Re-arrest" (2005). Paper presented to the Joint National Conference on Mental Health Block Grant and Mental Health Statistics. Washington, D.C.
[4] Jail housing cost estimates provided by the Harris County Budget Management Department as of February 28, 2015, and exclude one-time and overhead costs (e.g., inmate processing, courts, building and maintenance, utilities, etc.).

them to community-based services yields cost effective, positive treatment outcomes in the least restrictive environment.

Based on the high rates of incarceration, recidivism, and limitations in the mental health service capacity in jails, diversion is necessary. There is a continuing need for increased integrated mental health and substance use programs, respite and crisis stabilization services, and temporary and permanent supportive housing. The MHJDP program was designed to address these needs in Harris County.

4. Service Model

The MHJDP service model uses a collaborative model in which health and human services and criminal justice agencies work together to reduce recidivism for individuals with serious mental illness. MHJDP incorporates best practices from several evidence-based and empirically supported models and frameworks.

4.1 Critical Time Intervention Model

S.B. 1185 required MHJDP to incorporate CTI principles in its service model. CTI is an empirically supported, time-limited case management model used to assist people with behavioral health disorders transitioning from institutional settings, who are homeless or at risk of homelessness, by improving continuity of care and access to services during the critical transitional period. A fundamental aspect of CTI is that care should be tailored to each individual's specific needs.

CTI has successfully been used to treat vulnerable groups with similarities to individuals eligible for MHJDP, including:

- Formerly incarcerated individuals
- Homeless veterans
- Individuals with post-traumatic stress disorder (PTSD)
- Individuals formerly hospitalized for mental illness

Core elements of CTI used in the MHJDP model are:

- Small caseloads of 10 to 15 individuals per case manager, allowing for individualized needs to be addressed.
- Time-limited caseloads, where services are provided to individuals at the greatest intensity during the transitional period and reduced over time as they transition to community-based resources and support systems.
- Provision of two or three targeted services representing the primary needs of the individual to maintain stability, commonly including:
    - Mental health and substance use treatment
    - Crisis management
    - Residential and housing services
    - Life skills training
    - Government benefits services
    - Medicine management

- Money management
- Family intervention

The traditional CTI model is time-limited to nine months and includes three phases which each lasting approximately three months.

The first phase is *Transition to the Community*, which begins when the participants are first connected to the case manager. During this phase:

- Services and supports are provided by the case manager.
- Meetings are held frequently with the case manager.
- Connections are formed with other community agencies and organizations that can offer support.
- A treatment plan focused on the most crucial areas of intervention is created.

The second phase is *Try-Out*. During this phase clients begin to:

- Adjust to systems of support in the community.
- Build a support network.
- Problem-solve with the help of community supports and family.
- Slowly reduce contact with the case manager.

The third and final phase is *Transfer of Care*. During this phase:

- The client undergoes complete transfer to community supports and services.
- CTI services are ended after a transfer-of-care plan is established.
- The case manager monitors the client and responds to crises only.

4.2 Sequential Intercept Model

SIM was used as the framework for identifying individuals eligible for services and determining appropriate applied interventions. SIM was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) GAINS Center and includes five intercept points. Intercept points are critical opportunities for mental health and other professionals to intervene when individuals come into contact with law enforcement or the judiciary system.

The intercept points for mental health professional intervention are as follows:

- Intercept 1 interventions occur prior to the individual's arrest or jail booking at the time of initial law enforcement contact or experience of a 9-1-1 emergency.
- Intercept 2 interventions occur at the time an individual undergoes initial detention or court hearings.
- Intercept 3 interventions occur while the individual is awaiting a court ruling on a criminal case and involve making recommendations about short or long-term treatment options, such as referrals to specialty courts (e.g., veterans treatment, mental health, or drug) and ensuring medication and medical treatment are provided.
- Intercept 4 interventions occur when the individual is preparing for re-entry into the community after the criminal case is disposed and the individual is likely either adjudicated and placed on probation, or discharged from the state jail or prison system.

- Intercept 5 interventions occur after the individual's re-entry into the community with community supervision, probation, or parole and involve collaborating with law enforcement to ensure behavioral health services are provided.

4.3 Other Evidence-Based Practices

MHJDP also incorporated best practices from several other evidenced-based practices endorsed by SAMHSA.

4.3.1 Motivational Interviewing

MI is a clinical approach, used in diverse treatment settings with diverse populations, which encourages the clinician to express empathy and avoid arguing with the client while supporting the client's:

- Self-efficacy
- Willingness to accept responsibility for change
- Coping mechanisms
- Openness, instead of resistance, to change

4.3.2 Permanent Supportive Housing

PSH is an evidence-based practice used to help individuals with disabilities find permanent housing options to facilitate independent living and obligations to tenancy, such as paying rent. A component of the practice is linking people to long-term mental health and substance use treatment options that will facilitate retention of an independent living structure.

4.3.3 Trauma-Informed Care

TIC is a strengths-based approach where the practitioner helps the individual use personal and environmental strengths and resources to reach the upper limits of his or her capacity to grow and change. This practice recognizes the impact of trauma on an individual's coping mechanisms and on his or her physical, psychological, and emotional well-being. TIC includes interventions that are specifically geared towards reducing the likelihood of re-traumatization while providing treatment.

4.3.4 Cognitive Behavioral Therapy

CBT is a counseling-based treatment intervention targeting an individual’s thoughts and their impact on behavior. CBT is rooted in the belief that an individuals' view of his or her symptoms of mental illness or substance use can impact treatment prognosis. The goal of CBT is to replace maladaptive beliefs with healthier thoughts which will lead to better coping skills and outcomes.

5. Services

MHJDP’s approach applies principles of CTI to give participants access to targeted services during the first weeks following release from jail. As participants improve, they step down from

intensive case management to lower levels of care (see Appendices A-C for the step-down processes for each of the community-based service components).

The following is a list of MHJDP intensive services provided by case managers with low caseloads:

- Multilevel residential services: housing at group homes, 24-hour supervised congregate care facilities, and extended stay hotels.[5]
- Integrated health services: mental health and substance use services provided through hospitals, group homes, and intensive outpatient treatment options, involving coordination between behavioral health and medical providers.
- Benefits acquisition services or Social security income/social security disability income Outreach, Access, and Recovery (SOAR): assistance completing applications for Medicaid, Social Security Income, and Social Security Disability Income.
- Rehabilitation services: training for independent living, employment, substance use, mental health recovery, and criminogenic risk.
- Peer support: support provided by individuals with criminal justice and substance or mental health recovery experience.
- Basic needs assistance: services and assistance for utilities, rent or rent deposits, food, clothing, household items, transportation, and other needs.

Program services are designed to improve quality of life through increased access to housing, behavioral health, and social services and directly support the program's goals to reduce the frequency of arrests and incarcerations, number of days spent in jail, and criminogenic risk.

6. Eligibility

MHJDP booking, diagnostic, and exclusionary criteria were developed in partnership with the eligibility and assessment workgroup. This workgroup was composed of the jail medical director, specialty and county court staff, District Attorney's Office and Public Defender's Office - Mental Health Divisions, and behavioral health, homeless, and housing providers.

The eligibility criteria was developed to assist individuals with the highest risk of recidivism and severe mental illness in Harris County. Eligible individuals were required to have a diagnosis of any of the following, with or without a substance use disorder:

- Major depression
- Schizophrenia
- Bipolar disorder
- PTSD

[5] A housing first approach was used for individuals meeting the Housing and Urban Development (HUD) criteria for Permanent Supportive Housing (PSH), which includes four or more episodes of homelessness within the past three years, or one or more current consecutive years of homelessness. In addition, the individual must have a disabling condition which makes daily activities difficult (e.g., medical, psychological, substance abuse) and prevents holding a job.

PTSD was included because of the high incidence of trauma experienced by justice-involved individuals, and to extend MHJDP eligibility to veterans with at least three bookings in the last two years who were not otherwise eligible to receive behavioral health services through the Veteran's Administration.

Eligibility was also dependent on the individual scoring moderate (16-23) to high (24 and above) on the criminogenic risk Texas Risk Assessment System (TRAS) tool. TRAS was developed by the University of Cincinnati and is a validated tool for assessing adult offenders for criminogenic risk and the likelihood of future crimes. It is used statewide by Community Supervision and Corrections Departments (CSCDs).

Additionally, priority consideration for the program was given to individuals:

- Currently receiving treatment in the Harris County Jail Mental Health Unit
- With a history of receiving psychotropic medication in the Harris County Jail
- 18-35 years of age

The Harris County Office of Criminal Justice Coordination assisted in identifying aggregate data on the populations in need. An initial sample of individuals meeting the criteria was drawn to ensure sufficient numbers of eligible individuals would be found to populate the program.

6.1 Exclusionary Criteria

The Harris County MHJDP is a voluntary program and a basic level of cognitive functioning is required to participate. Cognitive functioning is determined by a uniform intake and psychosocial assessment and the Montreal Cognitive Assessment.

Specific exclusionary offenses include:

- Homicide
- Arson[6]
- Manufacturing or delivery of methamphetamine[7]
- Sexual offenses that require registry as a sex offender

Individuals with a current felony driving while intoxicated offense or current sex offense are evaluated on a case-by-case basis depending on severity of offense.

6.2 Referral Development

Potential MHJDP candidates are identified using a FDL based on a two-year rolling period for the three or more bookings required for eligibility (see Appendix D for example of FDL). The FDL data is compiled from multiple sources, including the Harris County Sheriff's Office, the District Clerk's Office, the local mental health authority (LMHA), and the Houston Coalition for the Homeless.

[6] Arson is an exclusionary offense because the exclusion is imposed on federal housing vouchers.
[7] Manufacturing or delivery of methamphetamine is an exclusionary offense because the exclusion is imposed on federal housing vouchers.

The list also identifies individuals who meet the mental health diagnosis criteria and if psychotropic medications were administered in the jail. A review of the candidates' criminal history using the Harris County District Clerk's website and the Justice Information Management System is required prior to referral. With the assistance of the Harris County Office of Criminal Justice Coordination, the bookings criteria for the list are updated monthly to include new candidates.

Jail referrals are reviewed on a daily basis using the FDL as a guide. Individuals who will be released from jail within 7-90 days are referred for screening. This allows staff sufficient time for the engagement and screening process. The majority of referrals and enrollments are produced through this process.

Candidates can also be referred through the Felony Court Referral Process (see Appendix E, Felony Court Offender Process) which also utilizes the FDL. Candidates with pending cases require approval from the Harris County District Attorney's Office, Mental Health Division designee. They identify individuals who will likely be sentenced to state jail. Once approved, voluntary consent is required from the prosecutor, defense attorney, and candidate. This process allows jail staff to prioritize individuals referred for assessment. If the defendant pleads to probation, the judge will have the discretion of making participation in the program (if enrolled) a condition of probation. Participation in the Harris County MHJDP program is not a determining factor in the revocation of the defendant's probation.

Referrals are also received from attorneys, judges, specialty courts (Felony Mental Health Court, Success Through Addiction Recovery [STAR] Drug Court, and Veteran's Court), law enforcement, Harris County CSCD, and family members. Other community referrals include service providers and the candidates themselves.

6.3 Screening and Assessment

Individuals who meet the eligibility criteria are referred for screening and assessment by the Harris County MHJDP administrative staff. A uniform screening and assessment process is used by all providers and includes the following:

- A uniform intake or psychosocial assessment to confirm a qualifying diagnosis
- A uniform assessment tool, TRAS, to assess criminogenic risk
- The Montreal Cognitive Assessment, to measure cognitive impairment
- Assessment of the individual's readiness for change
- Description of the individual's short- and long- term goals for treatment
- Assessment of the individual's willingness

Using this information, following MHJDP enrollment, the Assess, Plan, Identify, and Coordinate Model for persons transitioning from the jail is used. This model is a framework that focuses on critical elements for community re-entry of inmates and includes four key elements: assessment of needs, treatment planning, resource identification, and coordination of a transition plan.

The Daily Living Acitivities-20 (DLA-20) and Short Form Health Survey-36 assessments are used to measure client well-being at intake, at six months, and at program completion. DLA-20

measures functional improvement or lack thereof over time, while the Short Form Health Survey-36 comprises general quality-of-life measures.

7. Providers

The Harris County MHJDP operates through two main providers: The Harris Center for Mental Health and Intellectual and Developmental Disabilities (Harris Center) and The Coalition for the Homeless of Houston/Harris County (HHH) in partnership with SEARCH Homeless Services.

These two providers screen, assess, and enroll individuals. Individuals eligible for MHJDP are assigned to one of three community teams operated by HHH/SEARCH or the Harris Center based on specific team criteria.

Other providers are utilized for residential and other services.

7.1 HHH/SEARCH Teams

HHH/SEARCH provides medical and dental care, case management, and substance use counseling for individuals who are homeless and works to engage, stabilize, educate, employ, and house individuals who are homeless.

HHH/SEARCH operates the MHJDP PSH Team. The PSH Team uses the Coordinated Access System[8] to help eligible individuals receive a modified clinical assessment, apply for an apartment, receive case management support, and create goals if determined ready for independent living. This team serves individuals who:

- Meet Housing and Urban Development (HUD) criteria
- Obtain mandated records and documentation
- Are approved by the apartment complex identified as a housing option
- Are deemed ready for independent living

The chief executive officer, executive vice president, project supervisor, and director of social services overseeing the activities of PSH staff provide leadership for the HHH/SEARCH MHJDP team.

Primary care and behavioral health services are provided by a team comprised of a family medicine physician, a psychiatrist via telepsychiatry,[9] and a registered nurse, with support from a

[8] A homeless assessment system that is used to coordinate access to Rapid Rehousing and PSH, jointly overseen by HHH and the Corporation for Supportive Housing.

[9] Harris County follows the definition of telemedicine in the Texas Administrative Code §354.1430 for telepsychiatry which defines telemedicine as the practice of health care delivery, by a provider who is located at a site other than the site where the patient is located, for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. The provision of telemedicine services involves: (1) a patient site presenter responsible for presenting the patient for services; and (2) a distant site provider rendering consultation or evaluation for the purposes of diagnosis or treatment of the patient. The patient site presenters and distant site providers are restricted to certain provider types and locations as specified in the state's rules for Medicaid services.

medical case manager. Other key staff include a team lead, case managers, peer recovery support specialist, data entry clerk, community health workers, and an onsite registered nurse.

See Appendix H for information about the HHH-SEARCH PSH Service Component and Enrollment Process.

7.2 Harris Center Teams

The Harris Center is the local mental health and intellectual and developmental (IDD) authority for Harris County and operates the Community-Based, CTI, and Jail-Based Teams. It is also contracted to serve as the primary provider of mental health services for MHJDP.

The deputy director of forensic services, assistant deputy of adult justice services, and project administrator or practice manager provide leadership for the Harris Center MHJDP teams. Other key staff include an outcome analyst and three administrative staff members. Psychiatric services, such as medication management and psychiatric consultation, are provided through adult mental health clinics.

The following Harris Center MHJDP teams are comprised of a clinical team leader, licensed practitioners of the healing arts, licensed chemical dependency counselors, case managers, and peer support specialists.

The CTI Team implements the CTI Model with fidelity. This team serves individuals who meet at least one of the following criteria:

- TRAS score of 25 or above
- Identified as homeless or chronically homeless, but ineligible for PSH

The Harris Center Community Team provides intensive services in various geographical areas and community locations. Community teams serve people appropriate for the program who do not meet the criteria for the CTI or PSH Teams. In addition to providing the same services as the Jail-Based Teams, community team services are augmented by Consumer Benefits Case Managers trained in:

- SOAR
- Transportation
- Medication management services provided by psychiatric technicians

See Appendix G for information about the Community-Based Service Component and Enrollment Process.

The Jail-Based Team works in partnership with each Community Team. The Jail-Based Team provides screening and assessment services, and specialized interventions including:

- Co-occurring disorders treatment
- Group and individual therapy
- Evidence-based interventions for criminogenic risk factors
- Intensive case management and peer support services

See Appendix F for information about the Jail-Based Service Component/Enrollment Process.

7.3 Other Providers

The Harris County MHJDP also has contracts with temporary housing and substance use treatment providers. Temporary and emergency housing assistance is offered through group homes, residential programs, and extended stay hotels. Residential and day treatment programs are available for participants with co-occurring disorders. Enrolled participants can be referred from the jail or from the community. Service providers determine which program is most appropriate based on client choice and clinical need. To ensure continuity of care, they remain in contact with participants throughout the housing and treatment processes.

8. Program Evaluation

As legislatively mandated, MHJDP was evaluated by Harris County through a contract with UTHSCH. The evaluation showed, of the 4,155 individuals referred to MHJDP:

- 2,436 (58.6 percent) referrals *were determined ineligible* as a result of not meeting the three or more bookings criteria, not having a jail identifier personal number or System Person Number to view booking history, or having an exclusionary offense.
- 1,715 (41.2 percent) referrals *were not determined ineligible* at pre-screening.
- 215 (5.1 percent) referrals declined services during the pre-screening or eligibility screening processes.
- 1,385 referrals were engaged (which includes screening and assessment) in fiscal years 2015 and 2016.
- 554 of engaged referrals were enrolled in fiscal years 2015 and 2016.
- Most enrollments were from jail referrals, which the FDL uses to identify candidates appropriate for screening.

In addition, the evaluation indicates engagement services, such as counseling from a peer who has successfully completed treatment, provided to potentially eligible referrals significantly contributed to their eventual enrollment:

- 9.3 percent of referrals receiving less than one hour of engagement services were enrolled.
- 83.9 percent of referrals receiving 5 or more hours of engagement services were enrolled.

See Appendix J for post-jail engagement information.

8.1 Enrollment

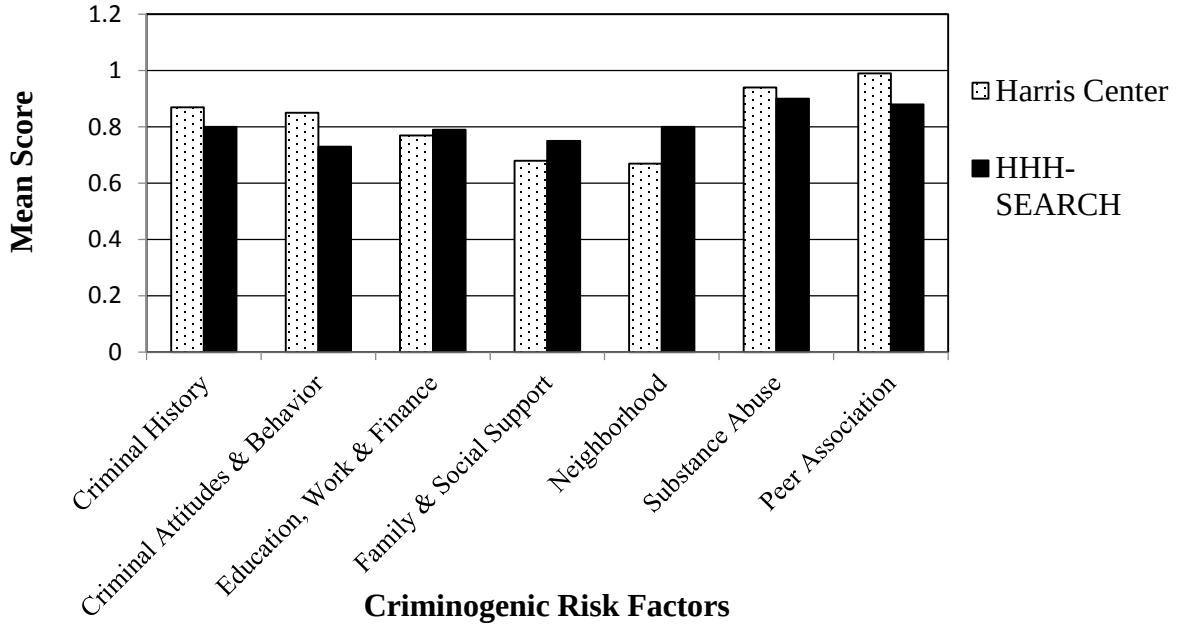
Notable characteristics of enrolled individuals (554) include:

- 99.3 percent were under the 2015 federal poverty level.
- 45.8 percent were classified as medically indigent.
- 23.8 percent received Medicaid benefits.
- 27.98 was the averaged TRAS score.

See Appendix K for additional demographic and other characteristics of enrolled participants.

Regarding TRAS score, the Harris County MHJDP criteria specifies moderate to high criminogenic risk TRAS scores as an eligibility requirement in order to target this population for treatment intervention. Mean TRAS scores of individuals enrolled are detailed in Figure 1, with TRAS sub scores (i.e., criminogenic risk factors) computed for both providers.

Figure 1: TRAS Sub-scores by Provider



Notable characteristics of individuals served by the two main provider groups include:

- 78 percent of enrolled individuals were served by the Harris Center.
- 22 percent of enrolled individuals were served by HHH/SEARCH.
- 144 out of the total 554 individuals enrolled (25.9 percent) were connected to a Harris Center clinic for psychiatric services.

Additionally, individuals enrolled in HHH/SEARCH remained in the program longer on average than those served by the Harris Center. However, individuals serviced by the Harris Center received significantly more services and engaged in services more. Most of these differences are consistent with the differences in targeted populations and services for each provider group.

See Appendix L for program tenure and hours by provider.

8.1.1 Program Discharges

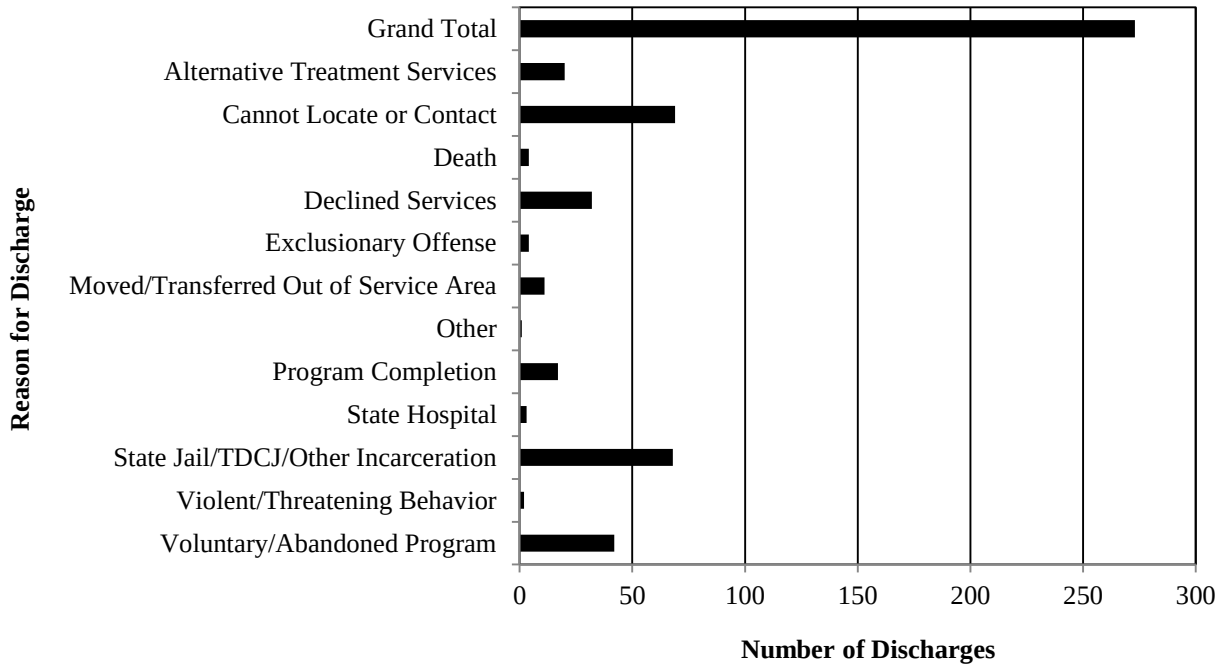
At the end of fiscal year 2016, 273 participants (49.2 percent) were discharged from the Harris County MHJDP. The top three causes of discharge were:

- 25 percent were closed due to staff's inability to locate or contact participants following release or shortly after engagment in the communty.

- 15 percent were closed following a participant's voluntary abandonment from housing or substance use treatment locations.
- 25 percent were closed following rebooking and sentencing to serve time at TDCJ, State Jail, or other facilities.

Additional reasons for discharge and their prevelance are summarized in Figure 2.

Figure 2: Reasons for Discharge



8.2 Outcomes

8.2.1 Sample Population

An analysis was conducted on a sample population of 203 individuals enrolled in the program. Members of the sample population had enrolled at least one year ago (prior to June 30, 2015), were served in the community, remained active in the treatment program for at least 30 days, and received at least five hours of service during that period.

The sample population was:
- 72 percent male
- 71 percent never married
- 98 percent English speaking
- 66 percent African American
- 36 percent living with bipolar disorder
- 43 percent living with a mental health disorder and a secondary substance use diagnosis

Trespassing, drug possession, theft, prostitution, assault, criminal mischief, and evading arrest were the most frequent charges for this population.

8.2.2 General Analysis Strategy

A "mirror analysis"[10] was conducted, comparing criminal justice involvement for the 203 individuals making up the sample population before entering the program and during the year following enrollment.

All participants had been in the jail three or more times in the previous two years. For the mirror analysis, the rate of bookings over the two-year period prior to their entry into the program was divided by two to provide a stable baseline annual figure for their criminal justice involvement. This average annual rate per year for participants was 2.09 bookings (range = 1.5 to 7 bookings, standard deviation = 0.797 bookings per year). During the first year following enrollment, 36.9 percent of individuals stayed out of the county jail.

8.2.3 Average Bookings per Person

In the pre-treatment phase, participants averaged 2 bookings per person. During the post-treatment phase, that rate had been reduced to 1.2 bookings per person, an average avoidance of 0.8 bookings per person. Table 1 shows the pre- and post-criminal justice measures per person, which include the number of jail bookings, charges, jail days, felonies, and misdemeanors. The total bookings avoided was 162.4 bookings.[11]

Table 1: Pre- and Post-Criminal Justice Measures

Time Period	Bookings	Charges	Jail Days	Felonies	Misdemeanors
Pre	2.0	2.5	87.6	0.9	1.5
Post	1.2	1.7	68.7	0.8	0.9
Total Reduction	**0.8**	**0.8**	**18.8**	**0.1**	**0.6**

Further analysis showed all individuals improved regardless of whether referred by the community or jail roster. Individuals assessed as having severe "criminogenic" behaviors and attitudes improved at a rate comparable to those with lower recidivism (see Appendix M for changes in bookings as it related to TRAS score severity level). Additionally, major mental health diagnostic groups responded equally well to the intervention.

[10]A "mirror analysis" examines the performance of all participants for identical periods before and after the initiation of treatment. So for instance, the study included a mirror analysis of each individual's booking rates for identical one-year periods before and after starting treatment with S.B. 1185 program. If a participant started on June 1, 2015, then his or her pre-test period would be June 1, 2014, to May 31, 2015. The person's post-test period would be June 1, 2015, to May 31, 2016.

[11] Bookings avoided was calculated by taking the number of people in the sample population multiplied by the average avoidance of booking per person.

8.2.4 Jail Days

Since bookings and jail stays are variable in length, changes in jail days were also examined. A reduction of 18.9 days per person per year was observed when the pre-treatment mean of 87.6 days was compared to the post-treatment mean of 68.7 days.

8.2.5 Impact on Public Psychiatric Hospital and Psychiatric Emergency Service Use

Enrolled individuals used Harris County Psychiatric Center services at a negligible rate of approximately 0.2 admissions per person per year before and after enrollment.

Enrolled individuals also used public psychiatric hospital bed days at a nominal rate before enrollment (1.6 bed days per person per year) and after (1.3 bed days per person per year), a non-significant change of 0.3 bed days per person per year.

Similarly, use of public psychiatric emergency services through the NeuroPsychiatric Center was not significantly impacted during the first year of program participation. The rate of emergency room visits changed only slightly by 0.4 visits per person per year. These findings suggest services provided by MHJDP (in lieu of incarceration) were not replaced by costly services in public hospitals and emergency rooms.

8.2.6 Housing Assistance and Substance Use Treatment Services

An estimated 403 participants (72.7 percent) were identified as homeless or in need of housing. In an effort to reduce homelessness and provide a safe environment for participants, the Harris County MHJDP provided housing assistance for up to 90 days (or more under special circumstances). Approximately 44 percent (246 participants) received temporary housing support following enrollment:

- 91 (16.4 percent) were placed in Permanent Supportive Housing units.
- 2 (0.4 percent) were placed in Permanent Supportive Housing units not funded by S.B. 1185.
- 38 (6.8 percent) were placed in other stable housing environments, such as apartments, residences of family or friends, and community rehabilitative programs.
- 28 (5 percent) refused housing assistance despite need.

Approximately 84 percent (468 participants) of all enrolled participants reported substance or alcohol use, and 13.7 percent of those (76 participants) refused treatment. The Harris County MHJDP began placing people in substance use residential treatment in August 2015:

- 63 participants (11.3 percent) received residential treatment averaging 27 days.
- 31 participants (49.2 percent) successfully completed the substance use program.
- 20 participants (33.3 percent) declined or dropped out of treatment following admission.

9. Recommendations

The Harris County MHJDP successfully implemented a system of care for individuals with co-occurring disorders, homelessness, and high criminogenic risk, assisting their ability to access integrated physical health, mental health, chemical dependency services, and other social rehabilitation services.

Based on the evaluation conducted by Harris County through a contract with UTHSCH, the program yielded positive results. After the first year of enrollment:

- Jail bookings decreased by 0.8 per person.
- Charges dropped decreased by 0.83 per person.
- Felonies and misdemeanors decreased by 0.14 and 0.68 per person, respectively.
- Jail days decreased by 18.9 days.

The program was highly utilized, receiving 4,155 referrals, engaging 1,385 individuals, and enrolling 554 individuals.

The outcomes of the pilot reveal benefits to the participants, Harris County, and the state, including:

- Diversion of eligible individuals from the criminal justice system, homelessness, and inpatient care through the provision of stable housing, benefits, employment, rehabilitation services, basic needs assistance, peer support, and other integrated health services.
- Reduced monetary costs to the state, county, and local communities due to reductions in justice system involvement and related cost savings.
- Alternative adjudication options to help participants receive treatment and avoiding incarceration.

9.1 Policy and Programmatic Recommendations

The pilot program supports the efficacy of the best practices outlined in the CTI treatment model. The recommendations regarding expansion of the model statewide could be implemented via existing local authority performance contracts.

- Ensure the Consolidated Local Area Service Plans required by HHSC performance contracts with the Local Mental Health and Behavioral Health Authorities include local jail diversion strategies which have a strong focus on interagency collaboration.
- Employ the best practices of SIM and CTI, as utilized in the pilot implemented in Harris County, in jail diversion projects, should funding be available for the expansion of jail diversion projects.

10. Conclusion

Based on available data, the Harris County MHJDP met its goal to reduce jail recidivism among persons with mental illness. The program successfully used core elements of the CTI model to provide comprehensive physical and behavioral health services to enrolled individuals during the critical transitional period after leaving an institutional setting.

The first year of program activity involved a comprehensive planning process between behavioral health, criminal justice, and law enforcement stakeholders. Early stakeholder input during the planning period enhanced the pilot program's effectiveness. These strong collaborations between local law enforcement, mental health agencies, and the courts provide a framework for sustainability essential to effective program implementation.

The pilot received 4,155 referrals with 1,385 individuals engaged (screened and assessed) in services. A total of 554 individuals enrolled in the program. Programmatic outcomes reveal a decrease in contact with law enforcement and shorter hospital stays.

List of Acronyms

Acronym	Full Name
CBT	Cognitive Behavioral Therapy
CSCD	Harris County Community Supervision and Corrections Department
CTI	Critical Time Intervention
DLA-20	Daily Living Acitivities-20
DSHS	Texas Department of State Health Services
FDL	Frequent Detainee List
FPL	Federal Poverty Level
H.B.	House Bill
HCJ	Harris County Jail
HHH	Healthcare for the Homeless-Houston
HHSC	Health and Human Services Commission
HUD	Housing and Urban Development
IDD	Intellectual and Developmental Disabilities
LMHA	Local Mental Health Authority
MHJDP	Mental Health Jail Diversion Program
MHSA	Mental Health and Substance Abuse
MI	Motivational Interviewing
PSH	Permanent Supportive Housing
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
S.B.	Senate Bill
SEARCH	Service and Emergency Aid Resource Center for the Homeless
SIM	Sequential Intercept Model
STAR	Success Through Addiction Recovery Drug Court
SOAR	Social Security Income/Social Security Disability Income Outreach, Access, and Recovery
TDCJ	Texas Department Criminal Justice

TIC	Trauma-Informed Care
TRAS	Texas Risk Assessment System
UTHSCH	University of Texas Health Science Center Houston

Appendix A: Harris Center Critical Time Intervention Team Step-Down Process

Screening/Eligibility

Interventions/Goals
- Contact individual and explain program.
- Begin building rapport.
- Complete screening, TRAS, psychosocial and Addiction Severity Index (ASI) assessments, and other assessments as needed.

Markers of Readiness for Enrollment
- Individual appears eligible and appropriate for services based on screening, TRAS and assessments.
- Individual gives consent to participate in program.
- Individual is accepted for enrollment into program.

Phase One (first 30 days)

Interventions/Goals
- Build rapport with individual.
- Engage in Critical Time Intervention planning to meet most urgent needs.
- Develop and implement individualized recovery/service plan.
- Address crises.
- Accompany individual to community resources as well as health and psychiatric appointments.
- Frequent face-to-face contacts with individual to address intensive Phase One needs.
- Assist individual with identifying supports and resources.
- Begin individual/group psychotherapy or substance use treatment as needed.
- Begin cognitive behavioral therapy group(s) & psycho-education group(s).

Markers of Readiness for Phase Two
- Successfully completed goals.
- Reduced frequency/severity of crises.
- Individual can manage symptoms & adheres to medication regimen.
- Individual has met with PCP w/follow up appointment scheduled.
- Individual has completed necessary applications for benefits & resources.
- Individual has progressed to a later stage of change.
- Individual may have reduced use of substances.
- Individual has identified a mode of transportation.

Phase Two (2-5 months)

Interventions/Goals
- Review Phase One achievements and identify both successes and areas for growth.
- Update individualized recovery/service plan.
- Address any continuing crises and assist individual in identifying a crisis plan.
- Attend appointments with limited assistance from CM; transportation provided as needed.
- Less frequent meetings with CM, once per week or biweekly.
- Solidify linkages to supports and community resources.
- Continue cognitive behavioral therapy group(s) & psycho-education group(s).

Markers of Readiness for Phase Three
- Successfully completed goals.
- Reduction in frequency/severity of crises.
- Individual has identified a crisis plan.
- Individual can plan ahead.
- Individual has engaged with benefits specialist or employment services to obtain income.
- Individual has identified a budget plan utilizing available resources.
- Individual can attend appointments & engage in most supports without assistance.
- Individual can identify pro-social activities.
- Individual can identify/utilize at least one coping skill to reduce criminal behavior.
- Individual has at least one long-term goal.

Phase Three (6-9 months)

Interventions/Goals
- Review Phase Two achievements and identify both successes and areas for growth.
- Update individualized recovery/service plan.
- Complete cognitive behavioral therapy group(s) & psycho-education group(s).
- Less frequent meetings with CM, regular check-in via phone calls, continued engagement with other staff including Psych Techs and Peer Support Specialists.
- Increase skills in communicating with health providers/professionals and participate more deeply in own physical and mental health treatment and management.
- Begin planning for completion of CTI program and possible step-down into Harris Center outpatient clinics or individual's preferred identified provider, including continuity of care plan for each identified area and program alumni activities.

Markers of Readiness for Step-Down
- Successfully completed goals.
- Individual can maintain all appointments without assistance.
- Individual can effectively communicate with providers and supports.
- Individual has ability to access and navigate reliable transportation options.
- Individual can identify and access contact information for all resources.
- Individual has a solid crisis plan in place.
- Individual can identify multiple pro-social activities to engage in on a weekly basis.
- Individual can identify/utilize multiple coping skills to reduce criminal behavior.
- Individual has multiple long-term goals along with steps to achieve those goals.

Recovery/Maintenance

- Individual is transferred to the Harris Center outpatient clinic services and/or other provider as appropriate.
- Individual can participate in SB1185 alumni activities as desired and receive a monthly contact by his/her Peer Support Specialist.

Appendix B: Harris Center Community Team Step-Down Process

Screening/Eligibility

Interventions/Goals
- Contact individual and explain program.
- Begin building rapport.
- Complete screening, TRAS, psychosocial and Addiction Severity Index (ASI) assessments, and other assessments as needed.

Engagement

Interventions/Goals
- Build rapport with individual.
- Engage in intensive case management services to meet most urgent needs.
- Develop and implement individualized recovery/service plan.
- Address crises.
- Frequent face-to-face contacts with individual to address intensive needs.
- Begin individual/group psychotherapy or substance use treatment as needed & cognitive behavioral therapy group(s) & psycho-education group(s).

Linkage and Referral

Activities/Goals
- Accompany individual to community resources as well as health and psychiatric appointments in order to build rapport and supports.
- Assist individual with identifying supports and resources.

Initial Recovery/Intensive Services

Interventions/Goals
- Review achievements and identify both successes and areas for growth.
- Update individualized recovery/service plan.
- Address any continuing crises and assist individual in identifying a crisis plan.
- Attend appointments with limited assistance from CM; transportation provided as needed.
- Less frequent meetings with CM, once per week or biweekly.
- Solidify linkages to supports and community resources.
- Continue cognitive behavioral therapy group(s) & psycho-education group(s).

Recovery/Maintenance

Interventions/Goals
- Review achievements and identify both successes and areas for growth.
- Complete cognitive behavioral therapy group(s) & psycho-education group(s).
- Less frequent meetings with CM, regular check-in via phone calls, continued engagement with other staff including Psych Techs and Peer Support Specialists.
- Increase skills in communicating with health providers/professionals and participate more deeply in own physical and mental health treatment and management.
- Engage in pro-social activities, such as involvement in a clubhouse, volunteer work, regular support group meetings, etc., on a weekly basis.
- Begin planning for completion of intensive services and possible step-down into Harris Center outpatient clinics or other provider, including continuity of care plan & alumni activities.

Continuity of Care

- Individual is transferred to the Harris Center outpatient clinic services and/or other provider as appropriate.
- Individual can participate in SB1185 alumni activities as desired and receive a monthly contact by his/her Peer Support Specialist.

Markers of Readiness for Enrollment
- Individual appears eligible and appropriate for services based on screening/assessments.
- Individual gives consent to participate in the program.
- Individual is accepted for enrollment.

Markers of Readiness for Completion of Linkage & Referral
- Successfully completed goals.
- Individual has identified a PCP and has a scheduled appointment.
- Individual has completed necessary applications & attended initial appointments for benefits & resources.
- Individual has completed necessary applications for identified resources with assistance from CM.
- Individual has identified thrift store(s) to obtain new clothes and food bank(s) for food.
- Individual has identified a mode of transportation.

Markers of Readiness for Recovery/Maintenance
- Successfully completed goals.
- Reduction in frequency/severity of crises.
- Individual can manage symptoms & adheres to medication regimen.
- Individual has progressed to a later stage of change.
- Individual may have reduced use of substances.
- Individual has identified a crisis plan.
- Individual can plan ahead.
- Individual can identify/utilize at least one coping skill to reduce criminal behavior.
- Individual can identify more than one long-term goal with steps to achieve those goals.
- Individual has identified a budget plan.
- Individual can attend appointments and engage with most supports without assistance.
- Individual can identify pro-social activities.

Markers of Readiness for Step-Down
- Successfully completed goals.
- Individual can maintain all appointments.
- Individual can effectively communicate with providers and supports.
- Individual can access/navigate transportation options.
- Individual can identify and utilize contact information for all community resources.
- Individual has a solid crisis plan in place.
- Individual can identify/utilize multiple coping skills to reduce criminal behavior.
- Reduction in frequency/severity of crises.
- Individual is working on long-term goal(s).
- Individual has engaged w/benefits specialist or employment services.
- Individual can attend appointments without assistance.
- Individual is engaged in pro-social activities.

Appendix C: Healthcare for the Homeless-Houston, Service and Emergency Aid Resource Center for the Homeless, and Permanent Supportive Housing Team Step-Down Process

Screening & Eligibility/Engagement

Tasks/Goals

- Build rapport and engage prospective individual. Orient individual to the PSH program.
- Complete screening, TRAS, and other assessments (as applicable).
- Strengthen change talk and commitment talk about moving into PSH.
- Assist with emergency housing and/or SU treatment prior to move-in (if applicable).
- Assist with completing the required applications and obtaining other documents necessary for acceptance into housing.
- Educate individual on rights and responsibilities as a tenant.
- Establish care with HHH – at least one physician's visit.
- Assist individual with meeting basic needs and linkages to resources.

Indicators of Readiness for PSH Move-In

- Individual has followed through on all tasks needed to enter housing.

Phase One: Transition to the Community

Tasks/Goals

- Move individual into housing.
- Orient individual to housing and living independently and to the community.
- Complete all initial assessments such as the SF-36 and DLA-20 w/in first two weeks of move-in.
- Create and work on 3-month goals and services plan.
- Address crises.
- Accompany individual to community resources as well as health/psychiatric appointments.
- More frequent visits with case manager on-site.
- Facilitate supports/resources & build collaboration w/property management, HHH, and other service and community providers.
- Begin individual/group psychotherapy or substance use treatment as needed as well as cognitive behavioral therapy group(s) and psycho-education group(s).

Indicators of Readiness for Phase Two

- Successfully completed all or part of the 3-month goals and services plan.
- Reduced frequency/severity of crises.
- Individual has established a routine.
- Individual has been connected to other services, supports, and relationships outside of PSH support system.
- Individual has identified a (crises) safety plan.
- Individual is able to maintain some appointments independently.

Phase Two: Try-Out

Tasks/Goals

- Review first 3-month plan – identify both successes and areas for growth as well as setbacks.
- Create and work on second 3-month goals and services plan and engage in discussion on long-term plans.
- Attend health/clinic appointments more independently.
- Meet with case manager on-site.
- Address crises with stronger emphasis on trigger awareness and access to coping strategies.
- Continue individual/group psychotherapy, substance use treatment & cognitive behavioral therapy group(s) and psycho-education group(s).
- Solidify linkages to supports and resources.

Indicators of Readiness for Step-Down

- Individual can identify coping skills and resources when in crisis.
- Individual's cognition moves from immediate/crisis to intermediate/planning.
- Individual is able to maintain almost all appointments independently.
- Individual has a wider network of supports and resources available.

Phase Three: Step-Down

Tasks/Goals

- Review second 3-month plan – identify both successes and areas for growth as well as setbacks.
- Create and work on 6-month goals and services plan.
- Complete cognitive behavioral therapy group(s) and psycho-education group(s).
- Meet with on-site case manager at least once a month although not required.
- Increase skills in communicating with health providers/professionals and participate more deeply in own physical and mental health treatment and management.
- Begin planning for completion of intensive services and possible step-down into continuity of care plan for each identified area.

Indicators of Readiness for Recovery/ Maintenance

- Individual can maintain all appointments independently.
- Individual is experiencing minimal crises.
- Individual has achieved financial and housing stability with only occasional setbacks.
- Individual has an established PCP and health home.
- Individual can effectively communicate with providers and supports.
- Individual has ability to access and navigate reliable transportation options.

Recovery/Maintenance

Tasks/Goals

- Practice and integrate Thinking for a Change skills and other learned coping skills.
- Assess and review goals and services plan every 6 months.
- Utilize PSH services as needed; increase independent utilization of resources and supports.
- Increase involvement in and contribution to the community.
- Maintain financial and housing stability with only occasional crises.

Appendix D: Frequent Detainee List

SB1185 Candidates

BJ=Big 3 Diagnosis **MH**=Mental Health **SA**=Substance **CH**=Chronically Homeless

MR=Mental Retardation **PD**=Personality Disorder **HHH**=HHH Client **PSH**=Permanent Supportive Housing

Alg=Meets Pub. Def. Algorithm **PTSD**=Post Traumatic Stress **HMIS**=HMIS Client **RRH**=Rapid Rehab Housing

List from (9/1/2014-8/31/2016) Total Count: 3048 - Meet Selection Criteria: 2492

SPN	In Jail	MHMRA No	Book Date	Cases	Court	Court Dt	Exp. Release	Name	DOB	SEX	Current Housing	Housing Type	CSCD POI	CSCD Unit	Pre Screened	Referred For Screening	Date Enrolled	Date Closed	On Meds	BJ	MR	Alg	PD	PTSD	SA	HHH	HMIS	CH	SSI	in PSH	in RRH	Ice Hold	Hold Agency
00000000	Y		9/27/2016	2	176	9/28/2016	Check		9/1/1991	M	PROC 109 01A	Other	KK	HHI					N	Y	N	Y	N	Y	Y	N	N	N	N	N	N	N	
00000000	Y		9/26/2016	1	015	9/27/2016	Check		9/4/1991	F	JA09 4D2A01S	MHU			11/3/2014	11/3/2014			Y	Y	N	Y	N	N	Y	N	Y	N	N	N	N	N	
00000000	Y		9/26/2016	1	008	9/27/2016	Check		9/5/1991	H	PROC 109 01A	Other							N	N	N	Y	N	Y	N	N	N	N	N	N	N	N	ASSAULT BI FAM MEM DETAINER
00000000	Y		9/25/2016	1	016	10/6/2016	Check		9/6/1991	F	JA09 4J1 01G	MHU			11/11/2015	11/11/2015	11/30/2015		N	Y	N	Y	N	N	Y	N	N	N	N	N	N	N	
00000000	Y		9/25/2016	1			Check		9/7/1991	H	JA09 6E1B02B	Other			3/4/2016	3/4/2016			Y	Y	N	Y	N	N	Y	N	Y	Y	N	N	N	N	
00000000	Y		9/25/2016	1	004	9/27/2016	Check		9/8/1991	H	JA09 2C1C01G	MHU			6/30/2015				Y	Y	Y	Y	N	N	Y	N	N	N	N	N	N	N	
00000000	Y		9/24/2016	1	004	9/27/2016	Check		9/9/1991	H	JA09 6H2A01A	Other							Y	Y	N	Y	Y	N	Y	N	N	N	N	N	N	N	
00000000	Y		9/24/2016	1			10/2/2016		9/10/1991	H	JA09 3H1 04F	Other			10/30/2015	10/30/2015	12/29/2015	2/8/2016	Y	Y	N	Y	N	N	Y	Y	Y	N	N	N	N	N	
00000000	Y		9/24/2016	1	012	9/30/2016	Check		9/11/1991	H	JA09 2F1 01J	Other							N	Y	N	Y	N	N	Y	N	Y	N	N	N	N	N	
00000000	Y		9/24/2016	2	001	9/30/2016	Check		9/12/1991	H	JA09 6H2B01C	WBTDT							N	Y	N	Y	N	N	Y	N	Y	N	N	N	N	N	
00000000	Y		9/24/2016	1	209	9/27/2016	Check		9/13/1991	H	JA09 6F2 02B	Other	S	SOUT	11/19/2014	3/14/2016	4/29/2016		Y	Y	N	Y	Y	Y	Y	N	Y	Y	N	N	N	N	
00000000	Y		9/23/2016	1	183	11/4/2016	Check		9/15/1991	F	JA09 H21601A	Medical							N	Y	N	Y	Y	N	Y	Y	Y	N	N	N	N	N	
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00000000	Y		9/23/2016	2	177	9/28/2016	Check		9/17/1991	F	JA04 1C2 02Q	Other	LC	CLO					N	Y	N	Y	N	N	Y	N	N	N	N	N	N	N	
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00000000	Y		9/22/2016	2	183	10/5/2016	Check		9/22/1991	H	JA09 2H1 01E	Other							Y	Y	N	Y	Y	N	Y	N	N	N	N	N	N	N	
00000000	Y		9/22/2016	1			Check		9/23/1991	H	JA09 MD1 01C	Detox							N	Y	N	Y	N	N	N	N	Y	N	N	N	N	N	
00000000	Y		9/22/2016	1	248	9/27/2016	Check		9/24/1991	H	JA07 4F3 01K	Other	A+	SAFP					N	Y	N	Y	N	N	N	N	N	N	N	N	N	N	BENCH WARRANT
00000000	Y		9/22/2016	2	180	10/28/2016	Check		9/25/1991	H	JA07 4C2 01H	Other			12/8/2014	12/8/2014			N	Y	N	Y	N	N	Y	N	N	N	N	N	N	N	
00000000	Y		9/22/2016	1	351	8/1/2017	Check		9/26/1991	F	JA09 4D2B01D	MHU			1/20/2016				Y	Y	N	Y	N	N	Y	N	Y	N	N	N	N	N	
00000000	Y		9/22/2016	2	208	10/28/2016	Check		9/27/1991	H	JA07 5B2 01T	Other							N	Y	N	Y	N	N	Y	N	N	N	N	N	N	N	
00000000	Y		9/21/2016	1	004	9/30/2016	Check		9/28/1991	H	JA09 2E2A01D	MHU	P1	PAF	7/9/2015	7/9/2015			Y	Y	N	Y	N	Y	Y	N	N	N	N	N	N	N	
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00000000	Y		9/21/2016	1	006	10/7/2016	Check		9/30/1991	H	JA09 2C1A01O	MHU							Y	Y	N	Y	N	N	N	N	N	N	N	N	N	N	
00000000	Y		9/21/2016	4	228	10/18/2016	Check		10/1/1991	H	JA09 6H2A01X	Substance Abuse	LM	CLO					Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	
	Y		9/21/2016	2	232	10/27/2016	Check		10/2/1991	H	JA09 6C2 03C	Other							Y	Y	N	Y	N	Y	Y	N	Y	N	N	N	N	N	
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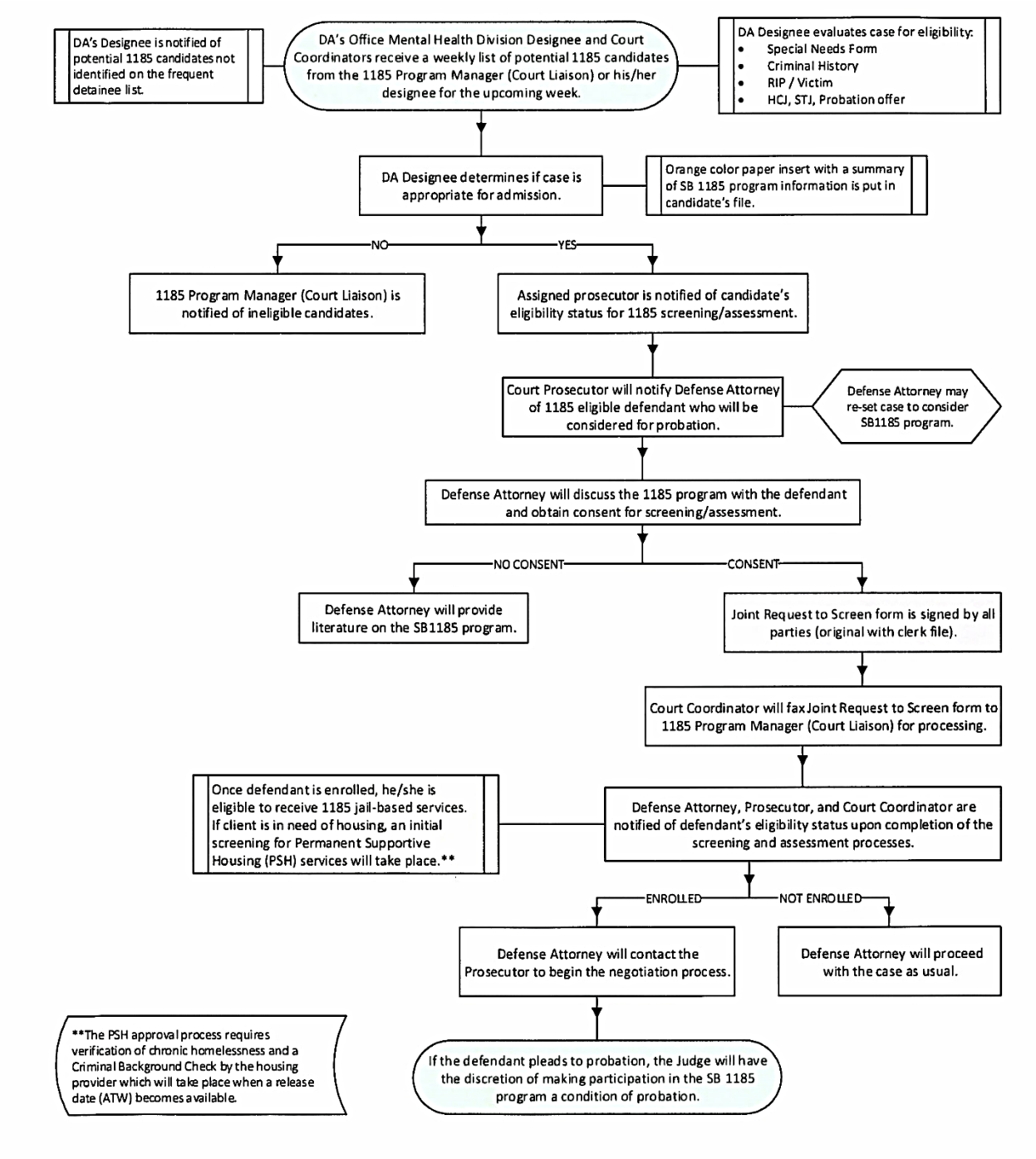
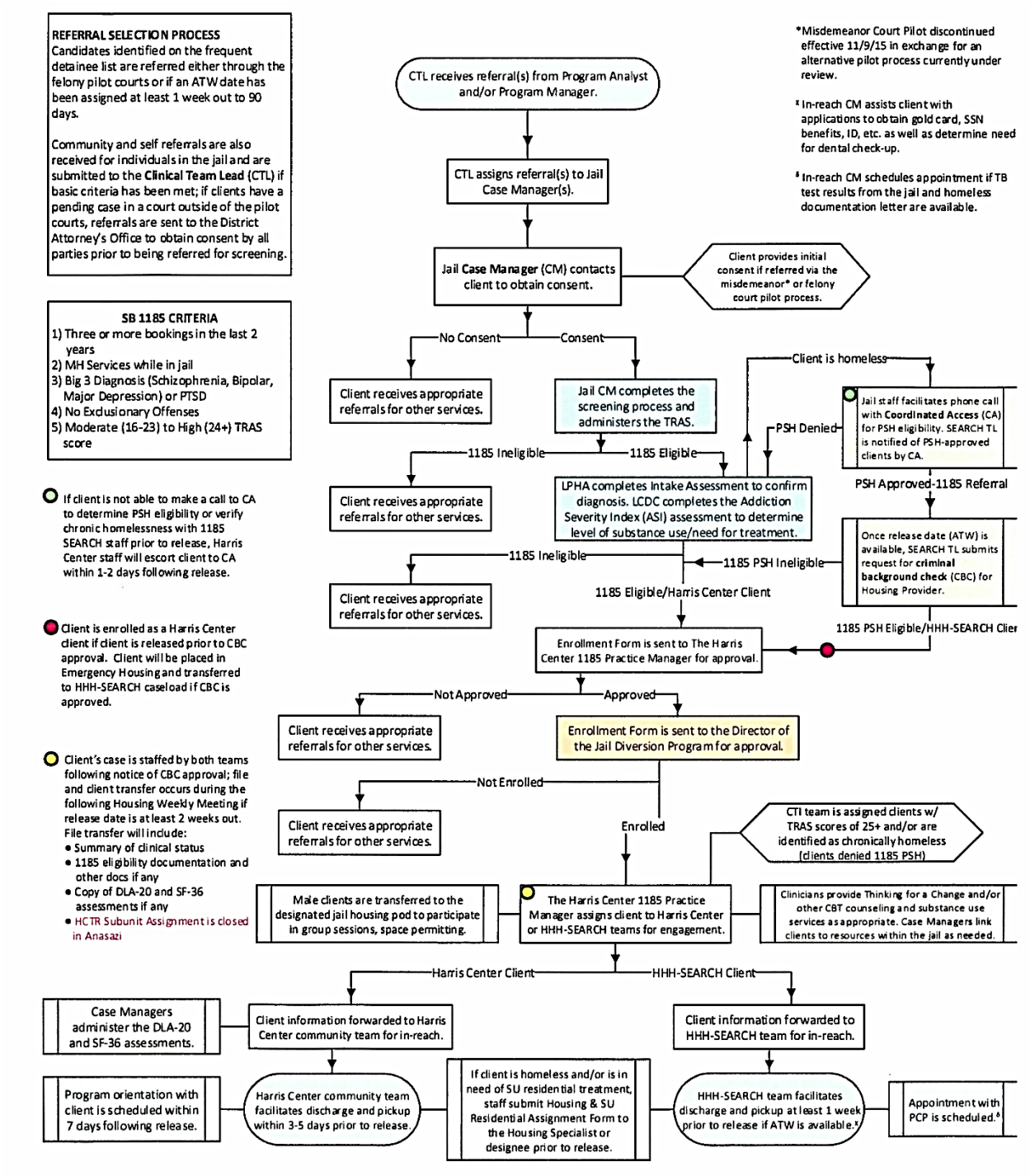
00000000	N						Check		10/25/1991	F		Other			1/27/2016	1/27/2016			N	Y	N	Y	N	N	Y	N	N	N	N	N	N	N	

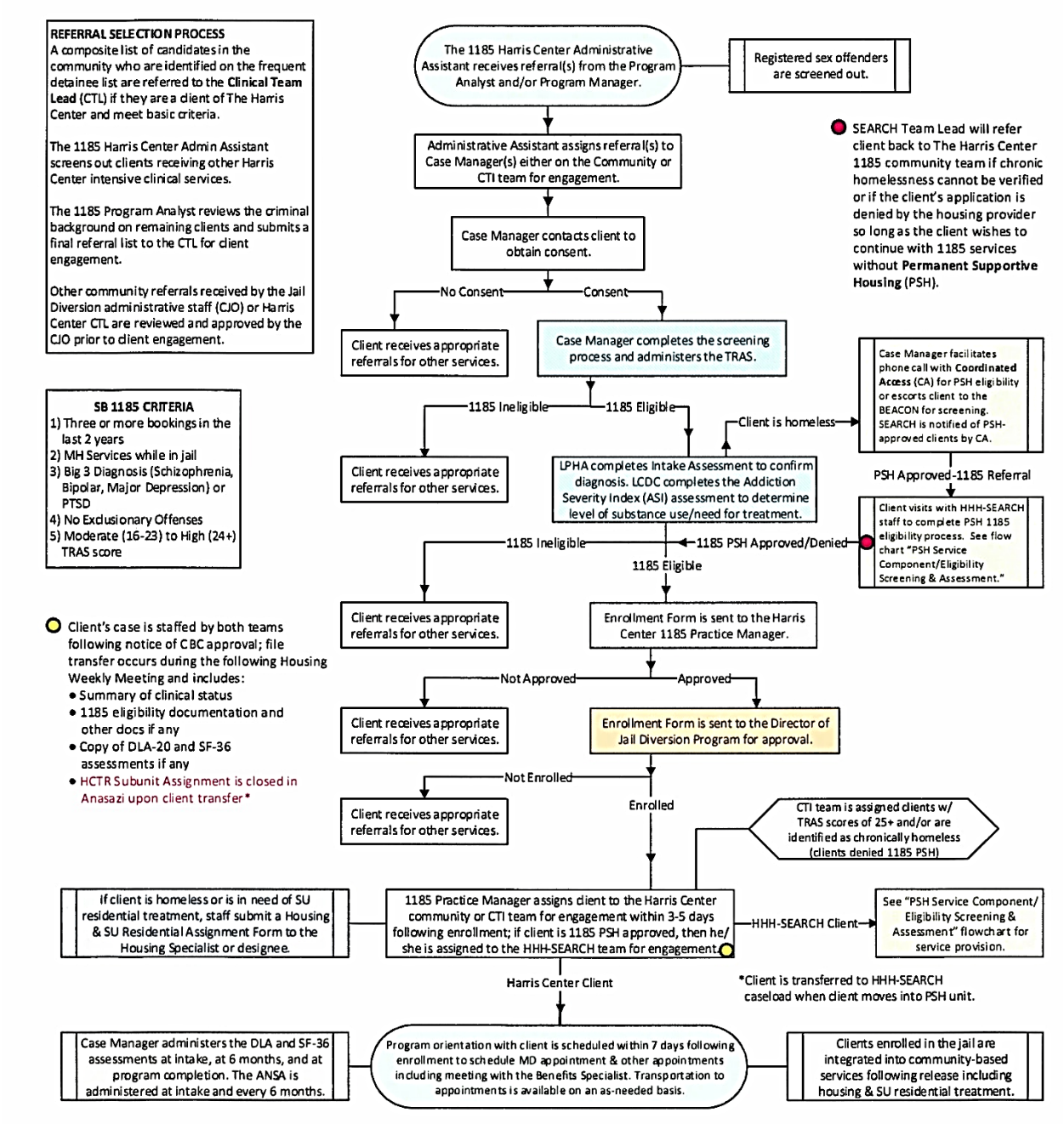
Appendix E: Felony Court Referral Process



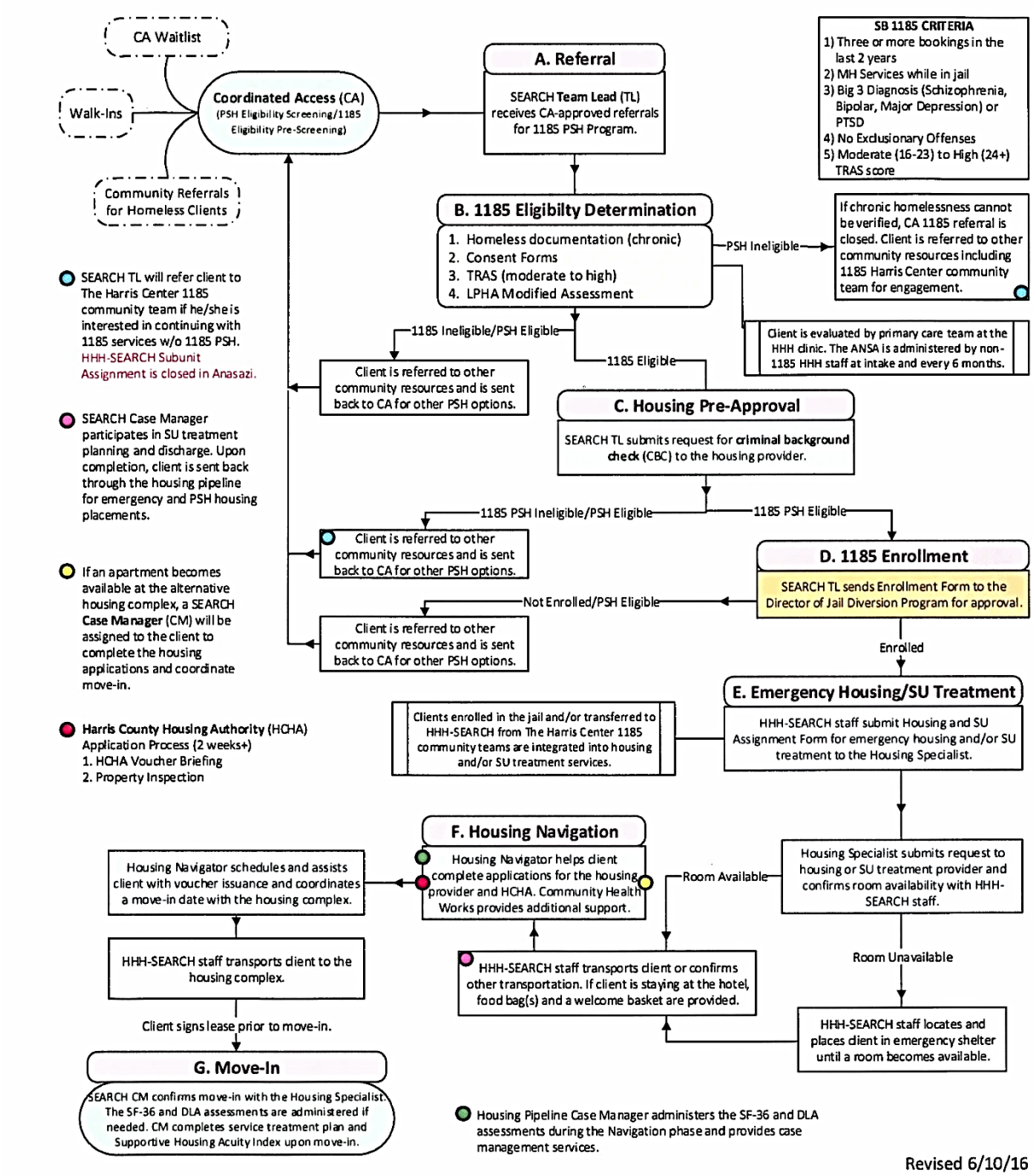
Appendix F: Harris County Jail-Based Service Component and Enrollment Process



Appendix G: Harris Center Community-Based Service Component and Enrollment Process



Appendix H: Healthcare for the Homeless-Houston, Service and Emergency Aid Resource Center for the Homeless, and Permanent Supportive Housing Service Component and Enrollment Process



Appendix I: Referral Source and Screening Outcome Based on Enrollment Status

Table 1: Referral Source

Referral Source	**Eligible**	**Ineligible**	**Unknown**	**Total**
Community Service Providers	312	1473		1785
Criminal Justice Community	259	491		750
FDL Community	250	26		276
FDL Jail	537	36		573
Other Community	23	15		38
PSH Walk-in	130	67		197
Self-Referred	194	324		518
Unknown	10	4	4	18
Total	**1,715**	**2,436**	**4**	**4,155**
Screening Outcome Status	**Eligible**	**Ineligible**	**Unknown**	**Total**
1185 PSH Eligible	2			2
1185 PSH Ineligible	23			23
Alternative Treatment Services		143		143
Cannot Locate or Contact	181			181
Cognitive Impairment		30		30
Deceased	2			2
Declined Services	195			195
Enrolled	554			554
Enrollment Pending	38			38
Exclusionary Offense		162		162
Extended HCJ Stay	1			1
Illegal Immigrant		1		1
Ineligible - Other		6		6
Ineligible Clinical		4		4

Low TRAS Score		4		4
No Follow Through	30			30
No SPN		516		516
Not Big 3 OR PTSD		36		36
Out of Service Area		7		7
Pending 1185 PSH Screening	14			14
Pending Case	114			114
Pending Eligibility Confirmation	23			23
Pending Eligibility Screening	371			371
Pending Referral for Screening	96			96
State Jail/TDC	71			71
Too Few Bookings		1527		1527
Unknown			4	4
Total	**1,715**	**2,436**	**4**	**4,155**

Notes: Referral Source and Screening Outcomes as of August 31, 2016. Community Service Providers include any community service provider including Harris County MHJDP Providers. Criminal Justice Community includes attorneys, judges, courts, Harris County Sheriff's Office, Community Service & Corrections Department, and state jail. FDL Community includes community referrals generated from FDL. FDL Jail includes jail referrals generated from FDL (1 week - 90 days). Other Community includes family, friends, and other unidentified community sources. PSH Walk-in includes individuals referred by Coordinated Access to the S.B. 1185 PSH Team. Approximately 573 (or 13.7 percent) candidates were referred more than once.

Appendix J: Post-Jail Engagement

The Harris County MHJDP has made every effort to try to engage potential participants in S.B. 1185 services. It has become strikingly evident efforts to engage individuals while in the jail will pay off in engagement with the program after release. The table below illustrates the relationship between hours of service in the jail to engagement in the program after release. As can be observed, the percentage of potential "recruits" who walk away from the program at jail discharge drops precipitously as the amount of time spent on engaging the participants' increases. Participants who received less than one hour of engagement service enrolled in the outpatient portion of the program at a rate of 9.35 percent. Those receiving five or more hours of engagement services were retained in outpatient service at an 83.92 percent rate. While potential recruits must agree to involvement in engagement activities (*i.e.*, "it takes two"), it is also evident, when potential recruits will allow, time is well spent on engagement.

Table 2. Post-Jail Engagement and Hours of Service in Jail Prior to Release

Service Hours to Participant Inside the Jail	Percentage Who Engaged in Service After Release from Jail	Number Engaged
Less than 1 Hour	9.3%	310
1-2 hours	35.2%	71
2-3 hours	50%	66
3-4 hours	71.3%	108
4-5 hours	74.6%	67
5 or more hours	83.9%	286
Total	**50%**	**908**

Appendix K: Enrolled Client Demographics and Other Characteristics

Table 3: Enrolled Client Demographics

Metric	Percentage of Participants	Number of Participants
Gender		
Male	71.8%	398
Female	28.2%	156
Age		
Mean Age		39.6
18-35 years old	41.9%	232
36-55 years old	49.8%	276
56 years and older	8.1%	45
Race		
White	34.5%	191
Black	65.0%	360
Other	0.6%	3
Ethnicity		
Hispanic	11.4%	63
Non-Hispanic	88.6%	491
Total Number Enrolled		554

Table 4: Demographics

Metric	Harris Center	HHH-SEARCH	Overall
Axis I Primary Mental Health Diagnosis			
Bipolar Disorder	192	57	249
Major Depressive Disorder	112	40	152
Schizophrenia	43	9	52

Schizoaffective Disorder	80	14	94
Post-Traumatic Stress Disorder	5	2	7
Total	**432**	**122**	**554**
Axis III Select Medical Conditions			
Hypertension	21	4	25
Asthma	5	2	7
Hepatitis C	1	2	3
HIV	9	1	10
Back Pain	2	1	3
Obesity	3	0	3
Epilepsy	9	0	9
Hyperlipidemia	1	0	1
Hyperthyroid	1	0	1
Esophagus Disorder	2	0	2
Diabetes	4	0	4
Substance Abuse			
Substance Abuse Disorder	198	42	240
No Substance Abuse	234	80	314
Homelessness[δ]			
Literally Homeless	141	0	141
Chronically Homeless	98	62	160
Total	**239**	**62**	**301**

[δ] Chronic homelessness is based on HUD's eligibility criteria to be approved for PSH; therefore, individuals who do not meet the criteria are literally homeless. Homeless status is determined at the time of enrollment and/or after an individual is assessed by Coordinated Access. However, housing needs may change during a participant's program tenure and therefore may be reassessed. Homeless status reported above as of August 31, 2016.

Table 5: Enrolled Client Health Characteristics Percentage of Enrolled Participants Living in Poverty

Metric	Percentage of Participants	Number of Participants
Living below the Federal Poverty Level (FPL)	99.3%	550
139% to 200% of FPL	0.2%	1
Unknown	0.5%	3

Table 6: Percentage of Enrolled Participants with Benefits

Metric	Percentage of Participants	Number of Participants
Medically Indigent	45.8%	254
Medicaid	23.8%	132
Medicare	1.3%	7
Medicaid Qualified Medicare Beneficiary	9%	50
Private Insurance	1.6%	9
Qualified Medicare Beneficiary	1.1%	6
Unknown	17.3%	96

Appendix L: Program Tenure and Hours Provided

Table 8: Program Tenure by Provider

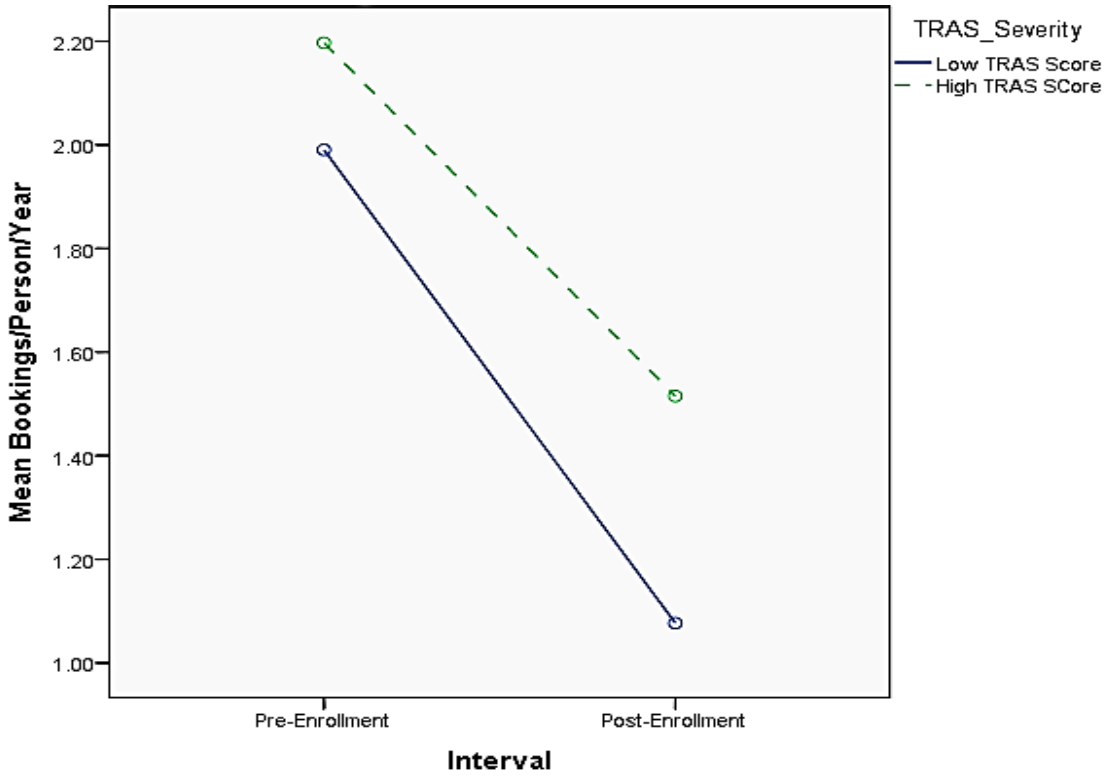
Metric	Harris Center	HHH-SEARCH	Overall
Closed Cases	**235**	**38**	**273**
Minimum Service Days	2	5	8
Maximum Service Days	547	603	1151
Mean Service Days	192.7	202.1	394.7
Active Cases	**197**	**84**	**281**
Minimum Service Days	2	2	4
Maximum Service Days	89	90	179
Mean Service Days	12.9	14.1	27

Table 9: Program Hours by Provider

Metric	Harris Center	HHH-SEARCH	Overall
Average of Total Service	181.7	101	168.1
Average Number of Services Provided	296.8	150.6	272.3
Total of Service Hours	22,315.9	4,544.4	26,860.4
Total Number of Participants	432	122	554

Note: The PSH model does not require its participants to engage in services to maintain housing.

Appendix M: Bookings by Texas Risk Assessment System Score Severity Before and After Program Enrollment



In order to explore whether severity of criminogenic attitudes and behaviors influenced treatment response, the sample was divided via median split (TRAS Score <=28 as Low Severity, TRAS Score >28=High Severity) and a 2 x 2 (TRAS Severity x Interval) repeated measures analysis of variance was performed. The resulting F-tests were significant for both the main effect for Interval (Pre vs. Post) $F=64.538$, $df=1$, $p<.001$ and the main effect for TRAS Severity ($F=4.844$, $df=1$, $p<.03$). The test of the interaction between these two main effects failed to reach significance ($F=1.325$, $df=1$, $p=251$). These findings may be interpreted as again demonstrating Pre-Post improvement in bookings. In addition, they demonstrate high-severity offenders are booked more frequently offering validation of the scale. Finally the results indicate the two groups did not respond differentially to the program. Rates of improvement were similar for both Severity groups with lower recidivism in each.

Appendix N: Harris County Estimated Maximum Cost per Adult Criminal Court Case

Harris County TX
County's Estimated Maximum Cost Per Adult Criminal Court Case Law Enforcement, Detention, and Court Activities
Fiscal Years: 2013, 2014, 2015 and 2016
Prepared: August 12, 2016

	FY 2013			FY 2014			FY 2015			FY 2016		
Disposed Criminal Cases Reported to the State												
District Criminal Courts	41,704			42,489			39,295			39,878		
County Criminal Courts	71,472			71,167			69,046			67,722		
Total District and County Criminal Disposed Cases	113,176			113,656			108,341			107,600		
HCSO Portion of DA Case Filings Applied to Cases Disposed[1]	22,408	20%		26,490	23%		28,037	26%		27,542	26%	
Constable Portion of DA Case Filings Applied to Cases Disposed	8,303	7%		8,310	7%		7,126	7%		6,888	6%	
Total Harris County Sheriff and Constable Portion	30,711	27%		34,800	31%		35,164	32%		34,430	32%	
	$s	**Cases**	**$s per Case**	**$s**	**Cases**	**$s per Case**	**$s**	**Cases**	**$s per Case**	**$s**	**Cases**	**$s per Case**
Law Enforcement and Detention Cost Per District/County Criminal Court Case												
Sheriff Law Enforcement[2]	$ 174,225,608	22,408	$ 7,775	$ 191,036,129	26,490	$ 7,212	$ 204,391,165	28,037	$ 7,290	$ 213,721,393	27,542	$ 7,760
Sheriff Detention	$ 155,632,883	113,176	$ 1,375	$ 159,159,128	113,656	$ 1,400	$ 159,668,157	108,341	$ 1,474	$ 164,165,828	107,600	$ 1,526
Sheriff Jail Health	$ 43,966,661	113,176	$ 388	$ 48,599,594	113,656	$ 428	$ 54,523,166	108,341	$ 503	$ 61,357,452	107,600	$ 570
Sheriff Building & Utilities	$ 14,391,152	113,176	$ 127	$ 14,742,213	113,656	$ 130	$ 14,484,871	108,341	$ 134	$ 15,286,812	107,600	$ 142
Total Sheriff's Cost Per District/County Criminal Court Case			$ 9,666			$ 9,169			$ 9,401			$ 9,998
CourtRelated Costs Per District/County Criminal Court Case												
Pretrial Services	$ 6,504,607	113,176	$ 57	$ 6,572,011	113,656	$ 58	$ 6,262,247	108,341	$ 58	$ 6,884,990	107,600	$ 64
District and County Criminal Court Appointed Attorneys	$ 23,048,101	113,176	$ 204	$ 27,526,394	113,656	$ 242	$ 28,121,042	108,341	$ 260	$ 30,972,260	107,600	$ 288
Public Defender	$ 8,302,207	113,176	$ 73	$ 8,413,636	113,656	$ 74	$ 8,376,743	108,341	$ 77	$ 8,978,025	107,600	$ 83
District and County Criminal Courts	$ 16,249,257	113,176	$ 144	$ 15,961,433	113,656	$ 140	$ 16,887,138	108,341	$ 156	$ 17,874,165	107,600	$ 166
District Attorney Criminal	$ 65,640,952	113,176	$ 580	$ 67,671,666	113,656	$ 595	$ 75,320,119	108,341	$ 695	$ 76,601,138	107,600	$ 712
Forensic Science	$ 10,191,675	30,711	$ 332	$ 12,360,241	34,800	$ 355	$ 13,161,179	35,164	$ 374	$ 14,064,653	34,430	$ 409
District Clerk for Criminal Courts	$ 15,887,348	113,176	$ 140	$ 15,854,068	113,656	$ 139	$ 17,569,280	108,341	$ 162	$ 20,653,054	107,600	$ 192
Sheriff Courts Division	$ 16,232,124	113,176	$ 143	$ 17,949,507	113,656	$ 158	$ 18,378,469	108,341	$ 170	$ 19,993,848	107,600	$ 186
Court of Appeals	$ 605,114	113,176	$ 5	$ 597,477	113,656	$ 5	$ 588,381	108,341	$ 5	$ 606,410	107,600	$ 6
Total CourtRelated Costs per Case			$ 1,679			$ 1,768			$ 1,957			$ 2,105
Estimated Maximum Cost Per County/District Criminal Court Case[3]			**$ 11,345**			**$ 10,937**			**$ 11,358**			**$ 12,103**

Notes

[1] HC Sheriff's Office cases filed for FY13, FY14, FY15 and FY16 as a percent of total cases filed with the HC District Attorney applied to the criminal court cases where applicable to ensure reasonable unit cost is obtained.

[2] Cases and cost figures related to other jurisdictions/agencies (e.g. HPD, Pasadena PD) are not examined, but are assumed to have comparable unit costs. Sheriff Law Enforcement includes Sheriff's Office activities that are criminal justice related in nature; however, may not be directly related to criminal court cases.

[3] Excludes JP cases and adult probation cost. Many costs are fixed or semivariable and therefore it would be incorrect to assume that jail population reduction or criminal cases disposed figures will result in corresponding cost savings.

Appendix O: Method Used to Calculate Harris County Estimated Criminal Court Costs

Harris County's estimated maximum cost per adult criminal court case is calculated based on adding select law enforcement, detention and court related costs for district and county criminal cases disposed for Harris County fiscal years 2013, 2014, 2015, and 2016.

Law enforcement and detention cost components include law enforcement, jail health, and the related building and utility costs. These costs represented an average of $9,558 per criminal case disposed with a range spanning from a low of $9,169 in fiscal year 2014 to a high of $9,998 in fiscal year 2016. For Harris County Sheriff's Office law enforcement cost per case, the portion of Harris County District Attorney's case filings disposed was calculated for each fiscal year as a percent of total criminal cases filed with the district attorney. For example, for fiscal year 2013, 20 percent or 20,647 cases filed with the District Attorney were filed by the Harris County Sheriff's Office whereas 80 percent or 83,634 cases were filed by 99 other law enforcement agencies. The 20 percent was then applied to the 113,176 total disposed criminal cases to obtain 22,408 cases attributed to the Harris County Sheriff's Office. Cases and cost figures related to the other 99 jurisdictions or agencies (e.g. Harris and Pasadena police departments) are not examined, but are assumed to have comparable unit costs. Harris County Sheriff's Office law enforcement includes Sheriff's Office activities that are criminal justice related in nature; however, may not be directly related to criminal court cases.

Court related costs components include pretrial services, District and County Appointed Attorneys, Public Defender, District and County Criminal Court Costs, Forensic Science, District Clerk for Criminal Courts, the Sheriff Courts Division, and the Court of Appeals.

Harris County Sheriff's Office excluded cost activities are comprised of the commissary, inmate industries, port security, motorist assistance, social security fraud, and donation fund costs. Court appointed attorney cost activities exclude child protective services, juvenile and justice court support division costs. Court management, the judges division, the court reporters division, and the hearing officer division are included at various reasonable allocations.

All expenditures from Pretrial Services, the Public Defender's Office, the 1st and 14th Courts of Appeals, and the District Attorney are included. Harris County Institute of Forensic Sciences expenditures are included for the Crime Laboratory Services and excluded for the Medical Examiner Service and are allocated for the Quality Management and Administration divisions. District Clerk expenditures are appropriately included, excluded, or allocated based on the criminal, civil, or shared-cost activity.

District and Criminal court cases disposed were obtained online from The Texas Office of Court Administration and exclude Justice of the Peace and adult probation cases.

As many of the costs tabulated are fixed or semi-variable in nature, it would be incorrect to assume jail population reduction or changes in criminal cases disposed figures would result in corresponding cost savings.

Appendix P: Estimated Harris County Jail Detention Costs

Estimated Harris County Jail Detention Costs
February 28, 2015
prepared by Harris County Budget Management

	Approximate Daily Cost Per Prisoner (Excluding One-time and OH Costs)[1]	Approximate Daily Cost Per Prisoner (Including One-time and OH Costs)
Detention Housing Costs		
General Population With No Health Issues	$52 - $57	$75 - $80
General Population Receiving Mental Health Medication	$62 - $67	$85 - $90
Specialized Mental Health Housing (Inside the Jail)	$222 - $232	$245 - $255
Overall Average Detention Cost	$60 - $65	$83 - $88

Notes:

[1] **One-time & Overhead costs include**: inmate processing, courts, building and maintenance, utilities, and allocated administration and county overhead. Many detention costs are fixed or semi-variable and therefore it is not correct to assume that jail population reductions will result in a corresponding cost savings equal to the amounts shown above. Actual cost reductions would be a function of the magnitude of the population reduction and the nature of the persons removed from the jail population.